

## WIC EBT Drop Ship Order Form Procedures

1. Clinic issues benefits onto the WIC Lone Star Card.
2. Participant is told not to buy the formula on the WIC Lone Star Card that is to be drop shipped. Participant acknowledges this by signing a statement on the WIC shopping list (see example on page 2). A copy of the Shopping List with the signed statement is filed in the participant's record.
3. Clinic contacts the Drop Ship Vendor to order the formula and obtain the price (without shipping and handling).
4. Clinic fills out the "To be completed by WIC Clinic" section of the *WIC EBT Formula Drop Ship Order Form* (see example below). ALL information must be entered, including the PAN.

### **To be completed by WIC Clinic:**

LA/Clinic #: 94-18 Clinic Phone #: 432-620-0080 Date of Order: 6/13/08

Clinic Contact (print name): Jennifer Lopez Benefit Month: June

Participant Name: Michael Harper DOB: 03/08/08 PAN#: 5077-1710-0101-2020-020

Vendor Store Name: Special Pharmacy Vendor Phone #: 512-555-5555

Vendor Representative Contacted: Nancy Kerrigan Vendor Fax #512-555-5551

### **Formula Requirements:**

Name	Size & Form	Code	Quantity	Unit Price
<b>Duocal</b>	<b>400G Powder</b>	<b>238</b>	<b>2</b>	<b>\$ 24.32</b>
				\$
				\$

SHIP TO Clinic/Other Address\*:

McCamey WIC Clinic  
East 7<sup>th</sup> Street  
McCamey, TX 79752

Special Shipping Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*State Agency approval **REQUIRED** for shipments to non-LA/Clinic address

5. Clinic faxes order form to the vendor.

6. Vendor completes the "To be Completed by Vendor" section of the *WIC EBT Formula Drop Ship Order Form* and ships the formula. If vendor includes the completed *WIC EBT Formula Drop Ship Order Form* as a packing slip, file the form in the participant's record.

<u>To be Completed by Vendor:</u>		WIC ACCOUNT # _____ OUTLET # _____		
UPC #	Pkg. (i.e. can, case)	Pkg Price	Qty Shipped	Claim Price
<b>Date Shipped:</b>	<b>Vendor Ref/Order#:</b>	Total Formula Cost		\$
<b>Vendor Signature:</b>		Shipping & Handling		\$
		Total Cost		\$

7. Clinic staff initial the original *WIC EBT Formula Drop Ship Order Form* (see example below), not the packing slip sent by the Vendor, indicating receipt of the formula. Clinic calls the participant to pick up the formula.
8. Participant signs the original *WIC EBT Formula Drop Ship Order Form* (see example below), not the packing slip sent by the Vendor, and receives the formula. The original *WIC EBT Formula Drop Ship Order Form* is faxed to the vendor and then filed in the participant's record.

<b><u>To be Completed by LA/Clinic Staff receiving and storing ordered formula(s):</u></b>	
Date shipment received: <u>6/15/08</u> initials: <u>JL</u>	
<i>After formula is received at the clinic, contact family to collect formula and obtain signature</i>	
<u>Judy Brice</u>	<u>6/15/08</u>
<i>Signature of Client/Parent/Guardian receiving formula</i>	<i>Date</i>

9. Vendor signs the *WIC EBT Formula Drop Ship Order Form* and mails it to the State agency Food Issuance and Redemption (FIRS) Unit.
10. State agency uses the signed *WIC EBT Formula Drop Ship Order Form* to pay the vendor.

### **Participant Acknowledgement Statement for the Shopping List**

<p>The WIC clinic has special ordered the formula _____ for my infant/child because it is not available locally. I understand that I am not to purchase any of this formula with my WIC Lone Star Card. If I receive the special formula from my clinic, and buy this product with my card, I will be held financially responsible for the cost of that formula.</p> <p><b>Participant's Signature</b> _____</p>
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## WIC EBT Formula Drop Ship Order Form

### To be completed by WIC clinic:

LA/Clinic #: \_\_\_\_\_ Clinic Phone #: \_\_\_\_\_ Date of Order: \_\_\_\_\_

Clinic Contact (print name): \_\_\_\_\_ Benefit Month: \_\_\_\_\_

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_ PAN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Vendor Store Name: \_\_\_\_\_ Vendor Phone #: \_\_\_\_\_

Vendor Representative Contacted: \_\_\_\_\_ Vendor Fax #: \_\_\_\_\_

### Formula Requirements:

Name	Size & Form	Code	Quantity	Unit Price
Shipping Charge				

Ship to clinic/other address\*:

Special shipping instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*State Agency approval REQUIRED for shipments to non-LA/Clinic address

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### To be completed by vendor:

WIC ACCOUNT #: \_\_\_\_\_ OUTLET #: \_\_\_\_\_

UPC #	Pkg (e.g. can, case)	Pkg Price	Qty Shipped	Claim Price
Date Shipped:	Vendor Ref/Order #	Total Formula Cost:		
Vendor Signature:		Shipping and Handling:		
		Total Cost:		

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### To be completed by LA/Clinic staff receiving and storing ordered formula(s):

Date shipment received: \_\_\_\_\_ Initials: \_\_\_\_\_

LA/Clinic: After formula is received at the clinic, contact family to collect formula and obtain signature.

\_\_\_\_\_  
Signature of Client/Parent/Guardian Receiving Formula

\_\_\_\_\_  
Date

LA/Clinic: FAX signed form to vendor when all shipments have been issued/signed for by the parent/guardian.

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<b>Vendor:</b> When form has client signature, please mail to <b>WIC Program – FIRS Unit</b> <b>4616 W. Howard Lane – Suite #275</b> <b>Austin, TX 78728</b>	<b>For State Use</b>	
	Claim File Name:	Promo/Claim#: